U.S. Department of Labor

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Issue Date: 25 February 2005

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In the Matter of:

LONNIE HOLMES,
Claimant,

v. **Case No. 2003-BLA-00273**

CLINCHFIELD COAL COMPANY/
PITTSTON COMPANY,
Employer/Carrier, and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party in Interest.
……..

Appearances:

Joseph Wolfe, Esq., Wolfe, Williamson and Rutherford, Norton, VA
For Claimant

Timothy W. Gresham, Esq. Penn Stuart & Eskridge, Abingdon, VA
For Employer/Carrier

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a duplicate or subsequent claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act"). The claim concerned here was filed by Claimant Lonnie Holmes ("Claimant") on January 10, 2001. The putative responsible operator is Clinchfield Coal Company ("Employer"). Because the district director granted the claim and the Employer continued to controvert Claimant's entitlement, the Black Lung Disability Trust Fund is paying benefits.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980. 20 C.F.R. § 718.2. These regulations were amended in

December 2000. *See* 65 Fed. Reg. 79,920 (Dec. 20, 2000). However, under 20 C.F.R. § 725.2, the 1999 version of specified sections are to be applied to claims (such as the instant claim) pending on January 19, 2001. Also, standards for the administration of clinical tests appearing in Subpart B of Part 718 (sections 718.101 through 718.107) only apply to evidence developed after January 19, 2001. In *National Mining Assn. v. Dept. of Labor*, 292 F.3d. 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit upheld a challenge to the amended regulations with the exception of several sections which were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting. The only one of the impermissibly retroactive regulations pertinent to the instant case is 20 C.F.R. § 718.204(a) (relating to total disability and providing that unrelated nonpulmonary or nonrespiratory conditions causing disability will not be considered in determining whether a miner is totally disabled due to pneumoconiosis); however, the amended rule is consistent with existing Fourth Circuit precedent. The Department of Labor amended these regulations on December 15, 2003 solely for the purpose of complying with the D.C. Circuit's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all evidence admitted and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

The instant claim is the second one filed by the Claimant.

Claimant's first claim was filed on June 3, 1993. (DX 34-1).[1] On December 22, 1994, Administrative Law Judge Joel R. Williams issued a "Decision and Order – Awarding Benefits." (DX 34-39).[2] On appeal to the Benefits Review Board ("Board"), the Board issued a June 28, 1995 decision that affirmed in part and vacated in part Judge Williams' decision and remanded for readjudication. (DX 34-43). The Board affirmed his findings under former sections 718.202(a)(1) to (3) and 718.204(c)(1) and (3) as unchallenged;[3] affirmed his finding that Dr. Forehand was the Claimant's treating physician but vacated his determination that Dr. Forehand's opinion was entitled to additional weight on that basis or because it was better reasoned; vacated his finding of pneumoconiosis based upon the medical opinion evidence; affirmed his finding of total disability based upon arterial blood gases (under former subsection (c)(2) [currently (a)(2)(ii)] of section 718.204) but vacated his finding of total disability based upon the medical opinion evidence; and vacated his disability causation analysis. *Id.* On remand, Judge Williams again awarded benefit in a remand decision and order of February 1, 1996. (DX 34-47). Again, the Board affirmed in part and vacated in part and remanded for

[1] References to exhibits admitted into evidence at the March 1, 2004 hearing appear as "DX" for Director's Exhibits,, "CX" for Claimant's Exhibits, and "EX" for Employer's Exhibits, followed by the exhibit number. Claimant's 1993 claim will be collectively referenced as "DX 34" and subparts will be referenced as "DX 34-1" through "DX 34-65."

[2] The transcript of the hearing before Judge Williams (held on October 5, 1994, according to his decision) is not of record and the district director has been unable to locate it.

[3] Although the Board stated in its September 1996 decision that it was also affirming Judge Williams' finding under section 718.204(b), in its later decision of September 1998, it admitted error in so stating in view of contradictory statements appearing elsewhere in the earlier opinion. (DX 34-65 at n. 2).

further consideration by decision of September 26, 1996. (DX 34-55). The Board vacated his finding of pneumoconiosis based upon the medical opinion evidence under *Warth v. Southern Ohio Coal Co.,* 60 F.3d 173 (4th Cir. 1995) in view of *Stiltner v. Island Creek Coal. Co.,* 86 F.3d 337 (4th Cir. 1996); affirmed his finding of total disability based upon the arterial blood gases as the "law of the case"; and vacated his finding of total disability under section 718.404(c)(4) based upon the medical opinion evidence and based upon all of the evidence on the issue. *Id.* Because Judge Williams was no longer with the Department, the case was reassigned. (DX 34-57). On September 3, 1997, Administrative Law Judge David W. Di Nardi issued a "Decision and Order on Remand – Denying Benefits." (DX 34-61). After indicating what issues had been resolved as the law of the case, Judge Di Nardi found that the Claimant had failed to establish that he suffered from pneumoconiosis based upon the medical opinion evidence under section 718.204(c)(4); that he had failed to establish a totally disabling respiratory impairment based upon the medical opinion evidence under section 718.204(c)(4); that he had failed to establish that he was totally disabled when all contrary probative evidence, alike and unlike, was considered; and that assuming, arguendo, that Claimant could establish the existence of pneumoconiosis, the claim would have to be denied because he failed to establish that he was totally disabled by it. *Id.* The Board affirmed the denial decision on September 29, 1998. (DX 34-65).

The instant claim was filed on January 10, 2001. (DX 1). An initial finding of entitlement was issued on March 26, 2001 and the Employer controverted the claim. (DX 22, 27). The district director issued a "Notice of Initial Determination" on July 11, 2001 which found Claimant to be entitled to benefits. (DX 29). On July 27, 2001, the Claimant was advised that interim benefits would be paid from the Trust Fund effective July 2001, and the case was transmitted to the Office of Administrative Law Judges on August 27, 2001. (DX 33, 35). A hearing was scheduled to be held before Judge Stuart Levin on March 7, 2002 but at the time of the hearing, the matter was remanded for consideration of evidence submitted by Claimant that was not in compliance with the 20-day rule [under 20 C.F.R. § 725.456]. (DX 46, 47, 48). Upon remand, the district director considered the newly submitted evidence and issued a "Proposed Decision and Order Following Remand," dated July 9, 2003, which again approved the claim. (DX 62). Employer again requested a hearing and the claim was transmitted to the Office of Administrative Law Judges on August 26, 2003. (DX 63, 64).

A hearing was held before the undersigned administrative law judge on March 1, 2004. Employer submitted a Prehearing Report under cover letter of February 10, 2004 that summarized the evidence. At the hearing, Director's Exhibits 1 through 64, Claimant's Exhibit 1, and Employer's Exhibits 1 through 9 were admitted into evidence. Claimant Lonnie Holmes was the only witness to testify. Upon conclusion of the hearing, the record was kept open for 30 days for the submission of one x-ray rereading by the Claimant (in response to EX 6, 7, and 8), and Employer's brief was to be submitted 30 days thereafter, with Claimant having 30 days to respond to anything requiring clarification. The Claimant decided not to submit an additional x-ray reading and the parties agreed to extend the briefing period for both parties until June 7, 2004, as advised by counsel for Employer's letter of May 6, 2004. Employer's Closing Argument, submitted under cover letter of June 7, 2004, was filed on June 10, 2004, and Claimant's Brief in Support of Award of Benefits, submitted under cover letter of June 4, 2004,

was filed on June 8, 2004. The joint motion for extension of time is **GRANTED** and the briefs or written closing arguments are accepted as timely. **SO ORDERED**.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

At the hearing, the Employer, through counsel, indicated that the issues of "Timeliness," "Miner" and "Post 1969 Employment" were withdrawn, and "Responsible Operator" was not contested. (Tr. 6 to 7). The issues are amended to so reflect. **SO ORDERED.**

The parties stipulated to 22 years of coal mine employment. (Tr. 6).

Accordingly, the issues for resolution by this tribunal are:

1. Dependency;

2. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled;

5. Whether Claimant's disability is due to pneumoconiosis;

6. Whether the evidence establishes a material change in conditions since the last prior denial (Subsequent Claim).

(DX 278; Tr. 7 to 14). Because the instant case involves the second claim filed by the Claimant, and the previous denial was final, there is a threshold issue – whether there has been a material change in conditions so as to reopen the claim under 20 C.F.R. §725.309 (1999).

Evidence

Claimant's Hearing Testimony

Claimant testified that he was last employed in the coal mining industry for Clinchfield (Employer) and that he worked there from approximately 1980 until November 1992. (Tr. 8-9). When he started working in the early 1960's, he hand loaded coal. (Tr. 9). His last job was as a pinner (or roof bolter), which involved drilling holes and putting pins and glue in the top (pinning the top). (Tr. 9-10). The drilling work produced "some dust." (Tr. 10).

Claimant testified that he was examined by Dr. Castle (for the Employer) in 2001. (Tr. 10). He testified that Dr. Castle refused to give him an exercise blood gas because of "a heart murmur or something." (Tr. 11). Dr. Rasmussen performed a blood gas. (Tr. 10). Claimant was also examined by Dr. Rasmussen twice, and his family doctor is Dr. Menelaos A. Voulgarropoulos. (Tr. 11-12). He was also treated by Dr. Ahmed I. Elnaggar. (Tr. 11-12).

Claimant testified that he would be unable to return to his work in the mines. (Tr. 12).

Claimant testified that he quit smoking in 1983. (Tr. 12). He does not smoke cigars, pipes or cigarettes, even occasionally. (Tr. 12). He started smoking when he was 12 or 13 years old [in approximately 1953] and averaged about one pack per day, amounting to a 30-pack-year smoking history.[4] (Tr. 13).

New Medical Evidence

The new medical evidence submitted since the time of the prior denial,[5] consists of interpretations of x-rays taken on November 16, 1999, January 21, 2000, February 7, 2001, May 30, 2001, July 12, 2001, September 10, 2001, January 29, 2002, June 26, 2002, and November 19, 2003; arterial blood gas studies taken on July 22, 1994, August 7, 1995, September 13, 1996, February 7, 2001, May 30, 2001, January 29, 2002, June 26, 2002, and November 19, 2003; pulmonary function tests (including diffusing capacity findings) performed on July 22, 1994, August 7, 1995, September 13, 1996, December 14, 2000, February 7, 2001, April 3, 2001, May 30, 2001, January 29, 2002, June 26, 2002, and November 19, 2003; reports and reviews of CT scans taken on November 29, 2000, March 19, 2001, April 10, 2001 (pre-biopsy), and June 4, 2001; electrocardiograms taken on February 7, 2001, May 30, 2001, January 29, 2002, June 26, 2002, and November 19, 2003; and the medical opinions of Gregory Fino, M.D. (dated September 12, 1994), J. Randolph Forehand, M.D. (dated February 7, 2001), James R. Castle, M.D. (dated May 30, 2001 and April 23, 2002), D. L. Rasmussen, M.D. (dated January 29, 2002 and November 19, 2003), Ahmed I. Elnaggar, M.D. (dated May 16, 2002), Kirk Hippensteel, M.D. (dated June 26, 2002); and the transcripts of Dr. J. Dale Sargent's September 20, 1994 deposition, Dr. Castle's February 25, 2002 deposition, and Dr. Hippensteel's February 20, 2004 deposition.

Discussion and Analysis

The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 28 BRBS 43 (CRT) (1994), the Supreme Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants.

Material Change in Conditions

As this is the second claim filed by the Claimant and the previous claim was finally denied on September 29, 1998 (when the Board affirmed Judge Di Nardi's September 3, 1997 remand decision), the instant claim is a duplicate or subsequent claim. Thus, there is a threshold issue as to whether it should be denied on the basis of the previous denial under 20 C.F.R. § 725.309. Because the instant claim was filed before January 19, 2001, the version of section

[4] As Claimant was born in 1941 (DX 1), he smoked cigarettes from approximately 1953 until 1983.

[5] Although the denial of the first claim did not become final until the Board's decision of September 29, 1998, Judge Williams' initial decision was issued on December 22, 1994. The evidence of record before him generally appears in DX 34, although two missing exhibits have been submitted in connection with this claim.

725.309 in effect prior to its December 2000 amendment is applicable to this issue. 20 C.F.R. §725.2. Under the 1999 version of section 725.309(d), a duplicate or subsequent claim should be denied based upon the prior denial unless the claimant can establish a material change in conditions. *See* 20 C.F.R. §725.309(d) (1999). Accordingly, the general rule is to require that the administrative law judge make a threshold determination as to whether the evidence submitted since the final denial is sufficient to establish a material change in conditions pursuant to 20 C.F.R. §725.309 (1999). If it is, the merits of the claim should be considered. If it is not, the claim must be denied.

This case arises under the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit, as the Claimant's usual and last coal mine employment took place in Virginia. *See* 20 C.F.R. §725.482. The standard for finding a "material change in conditions" is governed by the Fourth Circuit's holding in *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996) (en banc). In *Lisa Lee Mines*, the Court adopted the Director's one-element standard, "which requires the claimant to prove, under all of the probative medical evidence of his condition after the prior denial, at least one of the elements previously adjudicated against him." *Id.*

Judge Di Nardi denied the claim because the Claimant failed to establish pneumoconiosis, total disability, or causation of total disability. Thus, in order to establish a material change in conditions, the Claimant must establish one or more of these elements.

Extended discussion is unnecessary, however, as it is clear that the Claimant is currently incapable of performing his last and usual coal mine employment as a roof bolter.[6] In this regard, the regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). In addition to the presumption applicable to cases involving complicated pneumoconiosis, total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment or comparable work. 20 C.F.R. §718.204(b)(2). Here, although the pulmonary function studies are still nonqualifying and there is no evidence of cor pulmonale or congestive heart failure, the four new exercise ABGs are consistently qualifying, showing exercise-related hypoxia, and two of the six resting values were also qualifying.[7] More importantly, with the exception of Dr. Elnaggar

[6] The Board questioned Judge Williams' conclusion that Dr. Forehand knew what a roof bolter did, based upon the job title and Dr. Forehand's work with coal miners, as speculative and not "testimonially established" as required by *Walker v. Director, OWCP*, 927 F.2d 181 (4th Cir. 1991) and *Eagle v. Armco, Inc.,* 943 F.2d 509 (4th Cir. 1991). (DX 34-54). Here, each of the reviewing physicians took a work history as part of the examination.

[7] Although Employer has argued that one ABG did not produce qualifying results (Employer's Brief at p. 15), that statement is misleading because that test only included resting values. In fact, the doctor (Dr. Castle) refused to give the Claimant an exercise test because of "his history of cardiac arrhythmia and nonspecific changes on the electrocardiogram." (Tr. 9-10; EX 4). It would be speculative to assume that had that exercise test been performed, its results would have substantially varied from the other exercise values.

(who did not specifically address the issue), the physicians (including those retained by the Employer) who have reviewed recent clinical evidence in this case (Drs. Forehand, Castle, Rasmussen, and Hippensteel), agree that the Claimant is totally disabled based upon his pulmonary or respiratory condition from performing his coal mine work. As Claimant can now establish total disability under section 718.204, he has established a material change in conditions under *Lisa Lee.* Thus, the claim must be considered on its merits.

Pneumoconiosis

"Pneumoconiosis," commonly known as "black lung disease," is defined as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. §718.201(a) (2002). The definition has been modified to expressly include "both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal' pneumoconiosis." *Id.* The regulations define legal pneumoconiosis as "any chronic lung disease or impairment and its sequelae arising out of coal mine employment" and explain that "[t]his definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. §718.201(a)(2) (2002). The section continues by stating that "'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* at §718.201(b). Thus, a claimant miner who cannot prove clinical pneumoconiosis may prove the existence of legal pneumoconiosis if he or she can show that his or her lung condition was substantially aggravated by coal mine employment.

The regulations (in section 718.202(a)) provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting the x-rays; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 and two additional presumptions set forth in §718.305 and §718.306; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a)(1) - (4) (2002). A claimant must establish pneumoconiosis by a preponderance of the evidence after all of the evidence under each section is weighed together. *Island Creek Coal Co. v. Compton,* 211 F.3d 203 (4th Cir. 2000). Finally, under section 718.107, other medical evidence, and specifically the results of medically acceptable tests or procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered.

X-ray Evidence. Claimant has not proved the existence of pneumoconiosis by a preponderance of the new x-ray evidence. Of 70 readings of 20 x-rays, only 10 readings showed parenchymal abnormalities consistent with pneumoconiosis (although others found pleural abnormalities). Moreover, the preponderance of readings by the most qualified readers, who are dually qualified as B-readers and board-certified radiologists, failed to find parenchymal abnormalities consistent with pneumoconiosis. As discussed below, "positive" x-rays means those showing such abnormalities at a 1/0 or greater ("Category 1, 2, 3, A, B, or C") profusion. *See* 20 C.F.R. §718.102(b).

The newly submitted x-ray readings consist of 34 readings of nine x-rays taken on November 16, 1999, January 21, 2000, February 7, 2001, May 30, 2001, July 12, 2001, September 10, 2001, January 29, 2002, June 26, 2002, and November 19, 2003. Of these, seven readings of five x-rays (three relating to the February 7, 2001 x-ray, and one each relating to September 10, 2001, January 29, 2002, June 26, 2002, and November 19, 2003 x-rays) are positive for coal worker's pneumoconiosis (with readings of 1/1,t/q; 1/2 t/s, A; 1/1 p/q;1/0 r/p; 1/2, s/t; 1/0, s/t; 1/2, s/t), two produced equivocal results (of 0/1) and one was "unreadable." However, for each x-ray read as positive by one or more readers, there were at least as many negative readings by equally qualified readers, and five of the x-rays were found to be negative for pneumoconiosis by every reader. The most recent x-ray of November 19, 2003 was read by four dually qualified readers, qualified as both B-readers and board-certified radiologists, and was found to be positive by one of the readers and negative by the other three. Claimant cannot therefore establish pneumoconiosis based upon the new x-ray evidence which is, at best, in equipoise.

The evidence previously of record also does not support a finding of pneumoconiosis under section 718.202(a)(1). Judge Williams noted that of the numerous readings of 11 x-rays taken between March 1980 and February 1994, only three readings (relating to the July 21, 1993 and August 12, 1993 x-rays) were positive for pneumoconiosis [with readings of 1/2, q/r; 1/1, q/r; and 1/0, t/p] (in addition to "several" [actually four] 0/1 readings).[8] Judge Williams found that the Claimant had not established pneumoconiosis by the x-ray evidence. As Judge Di Nardi noted, that finding has become the law of the case.

Upon an independent review of all of the x-ray evidence, I note that the preponderance of the x-ray readings, old and new, including those by the most qualified readers, are negative for pneumoconiosis. Thus, Claimant cannot establish pneumoconiosis based upon the x-ray evidence under section 718.202(a)(1).

Biopsy Evidence. Claimant has failed to establish the presence of the disease under 20 C.F.R. §718.202(a)(2). In this regard, a report of a CT guided biopsy of the left lung dated April 10, 2001 by Robert M. Stevenson, M.D. was submitted. However, as the report notes, after performing the CT scan, it was determined that the mass to be biopsied was reduced in size and appeared to be resolving, and the other nodules in the sample were too small to biopsy. (DX 42). Thus, there is no biopsy evidence, and Claimant cannot establish pneumoconiosis under section 718.202(b).

Complicated Pneumoconiosis and Other Presumptions. A finding of "complicated pneumoconiosis" under 20 C.F.R. §718.304 results in an irrebuttable presumption of total disability. The only evidence of complicated pneumoconiosis is B-reader Dr. Goldstein's finding of category A pneumoconiosis based upon the February 7, 2001 x-ray. (DX 18). However, that same x-ray was interpreted by six other B-readers, none of whom found opacities of the size to be categorized as complicated pneumoconiosis (although two of the readers [Drs. Forehand and Barrett] found opacities consistent with simple coal workers' pneumoconiosis

[8] There were actually 28 negative readings and one "unreadable reading," in addition to the three positive (1/2 q/r, 1/1 q/r, and 1/1) and four equivocal (0/1) readings.

category 1 while a third [Dr. Dahhan] found opacities at a level of 0/1 and the remaining three [Drs. Sargent, Scott and Wheeler] found granulomas but no pneumoconiosis). Of these other readers, four [Drs. Sargent, Barrett, Scott, and Wheeler] are dually qualified as B-readers and board-certified radiologists. Thus, Dr. Goldstein's interpretation is outweighed by the interpretations of more qualified readers, who failed to find complicated pneumoconiosis based upon the same x-ray. I therefore find the section 718.304 presumption is inapplicable. The additional presumptions mentioned in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306, are also inapplicable, inter alia, because they do not apply to claims filed after January 1, 1982 or June 30, 1982, respectively, and section 718.306 only applies to death claims.

Medical Opinions on Pneumoconiosis. Claimant has also failed to establish the existence of the disease under 20 C.F.R. §718.202(a)(4) based upon the reasoned medical opinion evidence.

The Employer submitted the report and deposition transcript relating to the following physicians that were of record at one time (according to Judge Williams' opinion) but are not currently present in the Director's Exhibits:

(1) Gregory Fino, M.D., a board-certified pulmonologist,[9] reviewed the records and issued a report dated September 12, 1994 in which he opined that the Claimant did not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure. In so concluding, he relied upon mostly negative x-ray readings, "normal" spirometry which showed "a pure obstructive ventilatory abnormality" but no impairment; "normal" diffusing capacity values, and inconsistent findings of exercise-related hypoxia. (EX 1). Dr. Fino reviewed later (January 29, 2002 and June 26, 2002 x-rays and a November 29, 2000 CT scan, which he interpreted as negative for coal workers' pneumoconiosis [DX 44, 61], but did not otherwise update his opinion. Inasmuch as some of the factors that Dr. Fino relied upon (specifically, the normal diffusing capacity and the variability of exercise-related hypoxia) are no longer operative, I have no basis for concluding that Dr. Fino would have maintained the same opinion had he reviewed this additional data. Accordingly, I will give Dr. Fino's September 12, 1994 opinion no weight.

(2) J. Dale Sargent, M.D., a board-certified pulmonologist, gave his deposition on September 20, 1994 and the transcript of that deposition was submitted by the Employer. Dr. Sargent opined that coal dust could not be implicated as a cause for the Claimant's arterial blood gas abnormalities because one of the tests showed a normal response to exercise and other expected findings, such as a reduction in diffusing capacity, were not present. (EX 2 at p. 19-21) He also opined that the Claimant was not totally disabled from performing his last coal mine employment. (EX 2 at 23-24). Inasmuch as there were additional ABGs performed that consistently showed exercise induced hypoxia and the diffusion capacity is now reduced (e.g., DX 55, 57, 59), I have no basis for concluding that Dr. Sargent would have maintained the same opinion had he reviewed additional data and I therefore give Dr. Sargent's opinion as stated at his September 20, 1994 deposition no weight.

[9] As used herein, a board-certified pulmonologist is a physician who is board-certified in internal medicine and the subspecialty of pulmonary diseases.

The following physicians rendered opinions in connection with the instant claim:

(3) J. Randolph Forehand, M.D., who is board-certified in allergy and immunology, examined the Claimant for the Department of Labor on February 7, 2001.[10] (DX 10). He included detailed findings in his examination report, including an employment history, patient history, physical findings, and diagnostic testing results. Dr. Forehand diagnosed coal workers' pneumoconiosis and chronic bronchitis which he attributed to coal dust exposure and cigarette smoking. He concluded that the Claimant had a significant respiratory impairment and lacked sufficient residual oxygen transport capacity to return to last coal mining job. Dr. Forehand concluded that the principal factor accounting for the symptoms and test abnormalities was coal workers' pneumoconiosis with smoking contributing little to the overall loss of lung function. Dr. Forehand relied in part upon the CT scan evidence (which he interpreted as showing the effects of coal dust, asbestosis, and hard rock exposure) and the x-ray findings. (DX 10).

(4) James R. Castle, M.D., a board certified pulmonologist, examined the Claimant for the Employer on May 30, 2001 and reviewed the Claimant's medical records. In a report of June 21, 2001, he opined that the Claimant did not suffer from coal worker's pneumoconiosis, despite a sufficient work history, but that he did have findings consistent with tobacco smoke induced pulmonary emphysema with an asthmatic component as well as a pleural plaque consistent with asbestos exposure. He agreed that if Dr. Forehand's ABGs were accurate the Claimant would be disabled from his coal mine employment but disagreed with his assessment of the CT scan. (DX 37). In a followup report of April 23, 2002, Dr. Castle explained that he did not conduct an exercise ABG because of Claimant's history of cardiac arrhythmias and nonspecific changes on the electrocardiogram (EX 4). Dr. Castle explained his findings and conclusions further at his February 25, 2002 deposition, at which he opined that the Claimant was disabled from performing his last coal mine job as a result of tobacco smoke-induced pulmonary emphysema and bronchial asthma. (EX 3 at p. 25.)

(5) D. L. Rasmussen, M.D., a board certified internal medicine specialist, examined the Claimant (on his behalf) on January 29, 2002 and November 19, 2003. (DX 46, CX 1). In an examination report of January 29, 2002, he opined that it was medically reasonable to conclude that the Claimant had coal worker's pneumoconiosis arising from his coal mine employment. He noted that the Claimant did not retain the pulmonary capacity to perform his last regular coal mine job or any other nonsedentary job. He stated that the two known risk factors for the Claimant's impaired function are his coal mine dust exposure and cigarette smoking but that the "pattern of impairment (i.e. impaired oxygen transfer without significant ventilatory impairment) is more consistent with interstitial lung disease than with cigarette smoking alone" and he opined that coal mine dust exposure was the major cause of his impaired function. (DX 46). Dr. Rasmussen reached similar conclusions based upon his November 19, 2003 examination of the Claimant. In a report of the same date, he indicated that both cigarette smoking and coal mine dust exposure "undoubtedly contribute[d]" to the Claimant's disabling lung disease but that coal mine dust exposure remains the most important contributing factor. (CX 1).

[10] Although the Board affirmed Judge Williams' finding that Dr. Forehand was the Claimant's treating physician, I disagree with that finding. In any event, I will not assign additional weight to Dr. Forehand's opinion on that basis.

(6) Ahmed I. Elnaggar, M.D., the Claimant's treating physician, prepared a report dated May 16, 2002 in which he listed the diagnoses of moderate chronic obstructive pulmonary disease with emphysema and chronic asthmatic bronchitis, diabetes, hypertension, gastric reflux, history of irregular heart rate, and pulmonary fibrosis "most likely due to mixed-dust pneumoconiosis." (DX 55). He noted that the CT scans showed "chronic fibrotic lung disease occupying at least 2/3 of his lung fields bilaterally, most likely representing a case of mixed dust pneumoconiosis." He opined that the Claimant "has a mild case of mixed dust pneumoconiosis resulting in pulmonary fibrosis as well as a history of chronic obstructive pulmonary disease with a combination of emphysema and asthmatic bronchitis." (DX 55).

(7) Kirk Hippensteel, M.D., a board certified pulmonologist, examined the Claimant on June 26, 2002, reviewed the records, and prepared a July 18, 2002 examination report in which he opined that the Claimant had multiple medical problems that would keep him from going back to work at his previous job in the mines, with his gas exchange impairment with exercise the most significant factor in his impairment. He opined that the Claimant had a diffusion capacity due to bullous emphysema that was unrelated to his occupational history, based upon CT scan and x-ray findings. (DX 59) At Dr. Hippensteel's February 20, 2004 deposition, he further explained the basis for his opinion that, although "[t]he gas exchange impairment is certainly enough to keep him from going back to his job in the mines," the Claimant did not have coal worker's pneumoconiosis or any other chronic lung disease related to or aggravated by coal dust exposure. (EX 9 at 22-26).

In connection with the previous claim, during 1993 and 1994, Drs. Forehand and Sargent expressed opinions that are of record. (DX 34). I find the more recent opinions of Dr. Forehand to have more probative value than his earlier (July 1993 and November 1993) ones, and I assign no weight to the February 1994 opinion of Dr. Sargent for the same reason that I assign no weight to his September 1994 deposition. Accordingly, I will consider the medical opinions of Drs. Forehand, Castle, Rasmussen, Elnaggar and Hippensteel.

In weighing the medical evidence, I note that the United States Court of Appeals for the Fourth Circuit permits a finder of fact to give the opinion of an examining physician "especial consideration" when it is evaluated, although one cannot go so far as to "mechanistically" afford such opinion greater weight than that of a non-examining physician. *Millburn Colliery Co. v. Hicks*, 138 F.3d 524 (4th Cir. 1998); *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997) (citing *Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093 (4th Cir. 1993)). Similarly, the report of a non-examining physician cannot be discredited simply because the doctor did not examine the claimant, but the amount of weight given to a medical opinion is a decision left to the finder of fact. *See, e.g., Cole v. East Kentucky Collieries*, 20 B.L.R. 1-51, 1-55 (1996). *See also Scott v. Mason Coal Company*, 289 F.3d 263 (4th Cir. 2002). On the other hand, under *Hicks*, the opinions of physicians possessing superior credentials are entitled to additional weight based upon the theory that a physician's credentials are important indicators of the reliability of that physician's opinion, and the credentials of the treating physician as compared with those of the other physicians expressing opinions must therefore be considered in weighing the medical opinion evidence. The new regulation appearing at 20 C.F.R. §718.104(d) allows additional weight to be given to the opinion of a treating physician but requires certain

factors, including the nature and duration of the relationship, the frequency of treatment, and the extent of treatment, to be considered.

After reviewing the medical opinions with the above criteria in mind, I do not find a basis for selecting the opinions of Drs. Forehand, Rasmussen, and Elnaggar over the better documented and reasoned opinions of Drs. Hippensteel and Fino. *See Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-22 (BRB 1987) (stating that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and that a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). Each of the physicians expressing opinions in Claimant's favor relied in part on the x-ray evidence, which I have found to be equivocal on the issue of pneumoconiosis, the CT scan evidence, which tends to not support Claimant's view (as discussed below), and length of coal mine employment, which has been discounted by Fourth Circuit precedent (*e.g., Hicks, supra.*[finding no basis for ALJ crediting one physician's opinion over another's based upon its consistency with the Claimant's extensive history of coal mine employment and other findings]). The Fourth Circuit stated: "Just as the length of a miner's employment in the coal mines does not compel the conclusion that a miner's disability was entirely respiratory in nature, it does not conclusively establish that pneumoconiosis contributed to a totally disabling respiratory condition." *Id.* at 535.

In view of the above, I find that the medical opinion evidence does not preponderate in favor of a finding of pneumoconiosis. Under these circumstances, Claimant cannot establish pneumoconiosis based upon the medical opinion evidence.

Other Evidence. The only other new evidence relevant to the issue of pneumoconiosis consists of the CT scans and reviews, relating to CT scans taken on November 29, 2000, March 19, 2001, April 10, 2001, and June 4, 2001.[11]

A CT report by Daniel F. Sulser, M.D., a radiologist, relating to a CT scan of the chest with contrast performed on November 29, 2000 noted "severe apical bullous emphysema," "2 or 3 pulmonary nodules measuring less than 1 cm.," and "several areas of calcified pleural plaque." Dr. Sulser stated the following "Impressions":

1. Two or three small pulmonary nodules are clustered within the right upper lobe. The margins are smooth, suggest that these may be benign. However, these are non-calcified and need to be followed to assure stability.
2. Extensive apical bullous lung disease is noted. Also seen is scattered calcified pleural plaque which may reflect asbestos exposure.
3. No pathologically enlarged lymph nodes are seen.

(DX 14). Dr. Fino (a board-certified pulmonologist, not a radiologist) interpreted the same CT scan in a report of October 2, 2001, finding severe bullous emphysema but no pleural or

[11] In summarizing the CT scan interpretations, I have not included passing references in reports or at depositions. Although Dr. Elnaggar indicated that he reviewed all of the CT scans, he did not specify dates so I have only considered his report in connection with the April 2001 CT scan report by Dr. Stevenson, upon which Dr. Elnaggar's name was also stamped.

parenchymal abnormalities consistent with an occupational pneumoconiosis. Dr. Fino concluded: "There were no changes consistent with a coal mine dust associated occupational lung disease." (DX 44).

Another chest CT scan with IV contrast was taken on March 19, 2001. The hospital report is not of record, but the CT scan was reviewed by board certified radiologist Dr. Wheeler and board-certified pulmonologist Dr. Castle. (DX 44, 45). In a report of December 19, 2001, Dr. Wheeler noted multiple findings, including "no pneumoconiosis," a "3x2 cm mass or subsegmental atelectasis anterior right apex or apical pleural thickening from healed TB [tuberculosis]," moderate emphysema with blebs, decreased and distorted lung markings, calcified granulomas or nodules (ranging from tiny to 1 cm.) compatible with tuberculosis or histoplasmosis, pleural plaques or pleural fibrosis (suggesting asbestos exposure), and probable minimal obesity. (DX 44). Dr. Castle prepared a report dated February 4, 2002 in which he stated his opinion that March 19, 2001 scan (which had originally been dated March 5, 2001) showed no evidence of pneumoconiosis or complicated pneumoconiosis but that there was an anterior pleural based infiltrate that did not represent an area of pneumoconiosis or complicated pneumoconiosis; that there was evidence of significant bullous emphysema in both lungs with large bullae on the right; and that here were several calcified granulomata. (DX 45).

As noted above, a CT report by Robert M. Stevenson, M.D., a radiologist, relating to an April 10, 2001 CT guided biopsy of the left lung was submitted. However, no biopsy was conducted. The report notes that the blebs in the right lung were larger than they had been, the small nodule in the upper right lung "appears calcified and pleural based," the mass in the left apex previously noted had decreased in size approximately 50 percent and appeared to be resolving, there was stringy fibrotic appearing infiltrate suggesting it was inflammatory, the small nodules in the chest were less than a centimeter in size, and there were one to two pleural plaques noted in the right lung laterally which appear to be at least partially calcified. Dr. Stevenson recommended that, in view of the Claimant's severe COPD with marked bleb formation on the right and the reduction of the mass in size, it should be followed by CT; Dr. Elnaggar was advised of the results and the Claimant was advised to follow up with him. (DX 42). Dr. Elnaggar's name with a date of April 11, 2001 is stamped on this CT report. (DX 42). In his report of May 16, 2002, Dr. Elnaggar stated: "The patient has had multiple chest x-rays and CT scans in our facility and elsewhere, and all of his studies have been reviewed by myself personally, and he has chronic fibrotic lung disease occupying at least 2/3 of his lung fields bilaterally, most likely representing a case of mixed dust pneumoconiosis." (DX 55).

A fourth chest CT scan, also with IV contrast, was taken on June 4, 2001 and interpreted by Drs. Wheeler and Castle. The hospital report is not of record. In a report of December 19, 2001, Dr. Wheeler noted no pneumoconiosis; moderate emphysema with blebs and decreased and distorted lung markings; a few small bilateral pleural plaques; some focally calcified or pleural fibrosis more likely from old asbestos exposure than healed tuberculosis empyema; and obesity. Dr. Wheeler no longer mentioned the granulomas or nodules he had noted previously, and he remarked upon the absence of the atelectasis or mass from the anterior left apex that he had found on the March CT scan. (DX 44). Dr. Castle found that the CT scan of June 4, 2001 was "essentially the same as the previous scan." (DX 45).

In view of the above, while it is clear that the Claimant had significant lung abnormalities, some of which are possibly related to asbestos exposure, the CT scan evidence does not support a finding of coal mine dust associated disease. Dr. Elnaggar's conclusion that the CT scans show "chronic fibrotic lung disease occupying at least 2/3 of his lung fields bilaterally, most likely representing a case of mixed dust pneumoconiosis" is simply not substantiated by the interpretations of the radiologists, who are more qualified to interpret the CT scans. I find that the CT scan evidence does not support a finding that the Claimant has any form of coal-mine-dust-induced pneumoconiosis.

Section 718.202 as a Whole. Looking at the newly submitted evidence under section 718.202 as a whole, including the conflicting x-ray and CT scan interpretations and the inconsistent medical opinions, I find that the evidence on the issue of whether the Claimant has pneumoconiosis as defined in the Act and the regulations fails to preponderate in favor of such a finding. I reach the same conclusion when all the evidence of record, positive and negative, is considered. Therefore, the Claimant has failed to establish the existence of pneumoconiosis by a preponderance of the evidence.

Conclusion

Although the Claimant has established a material change in conditions based upon his current totally disabling respiratory impairment, this claim fails on the merits because the Claimant cannot establish that he suffers from pneumoconiosis. It is therefore unnecessary to consider any other issues.

ORDER

IT IS HEREBY ORDERED that the claim of Lonnie J. Holmes for black lung benefits under the Act be, and hereby is **DENIED.**

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PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.